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CANCER OF THE BLADDER

LOUIS M. ORR, M.D.

Orlando, Fla.

IN dealing with any of the major disease processes of the human body, such as cancer of the urinary bladder, one's concepts of the various therapeutic procedures broadens in direct ratio to experience and appreciation of the relative values of those procedures.

I will not undertake any discussion of the genesis of bladder cancer as it relates to known carcinogenic agents, and I have nothing to offer which would aid in a better understanding of the genetics of cancer cells. I say all this for the reason that in giving you my impressions of cancer of the urinary bladder I will dwell principally in broad generalizations and will avoid for the most part the usual tables of statistics and percentages of one sort or another.

These impressions have been formulated after a personal experience with over 300 bladder cancers, 95 per cent of which occurred in private patients. In analyzing the ultimate results in this group of patients, it has been found that year by year there has been a general improvement in results, keeping pace for the most part with results reported by others. This can be attributed principally, I believe, to improvement in adaptation of methods of therapy, and perhaps to a lesser degree to improvements in the basic technics in therapy.

From observations of this group of tumors, which in a large measure have been corroborated by pathological examination of the specimen, I have come to grossly classify tumors clinically into four general classes: (1) those tumors with slender pedicles which are

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easily visible, common to the so-called papilloma; (2) tumors with broad pedicles, which are believed to be those which have penetrated the basement membrane and invaded the vesical submucosa and at least down to or into the muscularis; (3) solid or sessile tumors with or without superficial ulcerations which appear as rounded or flat masses such as those which have penetrated deeply into the muscular layer, and (4) the ulcerative or crater-like type of tumor which is circumscribed by bullous edema, which has always been found not only to have penetrated the muscularis but to have also invaded the subvesical or preperitoneal fat, as the case may be. Oftentimes this type of tumor has been found firmly attached to the peritoneum or subtrigonal tissues. While it is realized that this is only a crude method of cataloging bladder tumors and subject to many inaccuracies, it has proved to be of value. I consider biopsies to be of greatest value *only* when the base of the tumor, including a portion of the bladder wall, can be removed for examination. In tumors with pedicles not too broad, which appear to be papillomatous, it is usually possible to dispose of the main body of the growth and then to take as deep a section as possible through the base. In this way a fairly accurate estimate can be obtained of the cellular content of the tumor stalk where it is attached to the bladder.

The preoperative determination of what will constitute adequate therapy to effect a cure has proved to be by no means always easy and the majority of failures to cure have been due to faulty interpretation of the type of growth to be dealt with. In trying to arrive at a proper appraisal of the activity of the tumor, its depth of penetration into the bladder wall and its direction of growth, great difficulty has been encountered. It has been shown that it is usually too late to wait for the pathologist to make a postoperative determination of the depth of penetration of the tumor before making a decision as to the type of therapy best suited for that particular tumor. It has been found that in only those cases where the tumor is superficially attached to the bladder wall, as in the tumor characterized by a cauliflower-like growth with moderately wide pedicle, has segmental resection alone been successful. Biopsy of the growth, either by deep bite with an adequate rongeur or sectioning with a resectoscope, has not been too helpful. At best, biopsies, as reported by Dean, are only 50 per cent accurate as regards the cellular structure when compared with examination of the bladder specimen removed *in toto*.

Bimanual palpation of the bladder under full anesthesia, as propounded by Jewett, has been of value only when it was certain that the invaded bladder wall was being palpated and not the intravesical tumor mass. This diagnostic measure I consider to be a not too

certain method of differentiation. It has been my experience that inability to palpate the invaded bladder wall can not be used as a criterion that the tumor is in every instance subject to complete removal either by segmental resection or by total cystectomy.

It has been a consistent finding that where the bladder wall could be palpated and found to resemble a firm or leathery mass the tumor was found to be inoperable. The statement by Jewett and Lewis that a differentiation between superficial and deep infiltration of the bladder wall could be established in 90 per cent of the cases by bimanual examination indicates a proficiency in this method of diagnosis not shared by many.

The former curator of the Army Medical Museum, Colonel Ash, states that the commonest type of tumor of the bladder is papilloma and that the epithelium is transitional, or better, urothelial. He further states that at least 80 per cent of the nearly 6,000 bladder tumors now in the carcinoma registry are, or were, originally papillomas. A dispute arises as to whether these should be classified as benign or malignant, or whether, as the registry has clearly decided, they should all be classified as carcinomas.

"Our decision is based upon the experience that it is impossible, certainly, for the pathologist to determine from the material that he has had an opportunity to study whether the tumor is to be clinically benign or malignant. We have numerous examples in the collection of tumors that, quite correctly, from histologic criteria, would be typical benign papillomas but which have proved clinically to be malignant and even to have metastasized."

Treatment: It seems generally accepted at this time that the curability of bladder cancer depends upon its cellular activity as related to the extent of dispersion and to depth of penetration. Furthermore, the cure of bladder cancer, irrespective of clinical or histologic pattern, unfortunately does not follow the fulfillment of any consistent requirements as to therapy. I say this because of the dangers always inherent in the innocuous-appearing papilloma which may represent itself as being a perfectly benign tumor, only in later years to manifest itself as a highly malignant, metastasizing neoplasm.

The choice of the most judicious therapy for bladder tumors is still controversial and opinion is at present divided on the use of surgery or radiation, or both.

Through rather bitter experiences it was learned years ago to consider all tumors of the bladder as being malignant. In a recent review of our records covering the past 20 years, it is clearly evident that we erred in placing too much trust in the report of the pathologist of the biopsy specimen and too little in our clinical evalua-

tion of the growth. It is probably true that a papilloma may show no malignant changes on cut section through the tumor, but this is by no mean surety that unseen anaplasia or metaplasia is not present at some place in the pedicle. Only too often some unknown potential manifests itself in a malignant recurrence. Flocks has only recently reported the results of transurethral resections of a large group of tumors. His five-year results in the control of tumors which invaded the submucosa and superficial muscularis are surprisingly good, but his unsatisfactory results in the more invasive types of tumors demonstrates quite clearly the ineffectiveness of this method of therapy when it is applied to all types of tumors. Other reports now current make claim to the cure of *infiltrating* bladder cancer in certain instances by excision with a resectoscope loop. It is no doubt true that the resectoscope can be used in certain instances to eliminate, temporarily at least, any evidence of the tumor, and no doubt it is oftentimes possible to effect a cure; but, unfortunately, the indiscreet use of the instrument in this manner is one of the more evil uses to which it has been put—and many have been its evil uses.

In the therapy of bladder cancer by radiation, Barringer in 1939 reported 24.1 per cent cured by the use of direct application of radiation to the tumor. Marshall, however, in 1947, reported that only 6 per cent of radiation treated patients were free of cancer at the end of five years. Others have reported varying results. Huggins has made the statement that "the use of radiant energy through radium or radon seems to be declining rapidly in this country." No doubt this assertion is open to considerable controversy. Hellstrom, of Stockholm, reports the use of radium, usually in conjunction with surgery, in about 30 per cent of 307 patients treated for bladder tumor. Ash has stated that "he doubted that any cancer of the bladder that could be cured by radiation could not be cured by surgery." In spite of differences of opinion as to the use of radium, very heartening results are sometimes encountered.

Jewett has shown conclusively that segmental bladder resection is effective in only those types of tumors which have penetrated into the submucosa and/or into the superficial portion of the muscularis of the bladder. It is to be noted in his report that all the patients with tumors falling into these two categories were reported living five years following partial cystectomy or segmental resection. In those patients with tumors which had penetrated deep into the muscularis, and also those with tumors which penetrated the entire bladder wall, all were reported as having died with recurrent carcinoma of the bladder wall with the exception of a single five-year survivor. While Jewett's differential classification represents nar-

row zones of histologic demarkation, the results he has reported demonstrate the types of tumors curable by segmental resection. Those same types might also have been cured by other measures less radical, as Flocks, Milner and others have reported.

It has been our experience that the location of the tumor, as well as the cystoscopic appearance, is an important factor in considering segmental resection as a procedure likely to effect a cure. We have found that as a general rule the nearer the neoplasm is to the vertex of the bladder, the wider can be the resection and the more likely a cure effected. We have in our files one patient with an infiltrating carcinoma of the vertex of the bladder who is now living 12 years after segmental resection. Conversely, it has also been found that tumors involving the trigone, with the exception of the most superficial villous types, have not been cured by segmental resection. It seems not unreasonable to expect such results when study is given to the venous and lymph drainage of the bladder. Hellstrom has recently called attention to this in reporting recurrent growths at the margin of wide segmental bladder resections. He mentioned one instance of cancer cells being found in the lymphatic channels at the edge of the excised cuff when it had been presumed that an adequate segmental resection had been carried out.

McDonald, of the Mayo Clinic, in a recent analysis of surgically removed bladder cancers, emphasizes the importance in prognosis and treatment of the presence or absence of vascular invasion. He further states that it is important to know whether or not infiltration of the bladder wall has occurred and if so, whether there has been invasion of the perivesical fat. These statements are all too true but such information is almost impossible to obtain preoperatively. Determination of the *true* anatomic and histologic status of the tumor, unfortunately, is almost always found in the pathologist's report days after the surgery has been performed, oftentimes too late for the operator to do *more* toward radical removal than might have been done.

Before 1942 we had become conscious of our inability to obtain satisfactory results with segmental resection alone in deeply penetrating cancer and resorted to the supplementary use of radium on both sides of the bladder wall closure because of the possibility of invasion of the perivesical fat by contiguity of tissue. This was carried out in 22 patients. Radium emanations in the form of radon were most commonly used because of the seemingly better regulated dosage and less severe reaction from radiation. Because of the disruption of nearly four years' war service, it was impossible to trace the majority of these pre-war patients. Only one patient of this

group was found to be free of tumor after seven years. All others who could be traced were dead of causes unknown.

Of 62 patients with bladder cancer treated between Jan. 1, 1946, and October, 1948, radon has been used in conjunction with segmental resection in 10 cases. Two of these patients died of recurrent cancer near the site of resection within 12 months. The remaining 8 are free of cancer after two, three or four years. Four of the 62 were treated by segmental resection without the use of radon, all of whom are at present without evidence of recurrence. Six patients in this group were found to be inoperable, 3 of whom underwent ureteral transplantation as a palliative measure. Seven were deemed suitable for cystectomy, 1 of whom died of local recurrence of cancer in the pelvic region within one year following the operation, and 2 died of intercurrent causes following ureteral transplantation before cystectomy could be performed. Three of the other 4 patients were all dead within two years. The remaining number of patients with tumors showed no clinical evidence of infiltration and were treated by endoscopic means. All of these patients who have permitted adequate follow-up during the 32 months' period are at present without evidence of tumor and are considered as being at least controlled at the present.

Of the above mentioned 10 patients undergoing segmental resection with the supplemental use of radium, 4 were found to have deep infiltration of the bladder wall. All 4 are at the present free of any evidence of cancer. Another patient with what appeared to be an inoperable cancer of the bladder trigone, involving both ureteral orifices, was treated by suprapubic cystotomy and radon implantation only, as neither segmental resection nor cystectomy was considered practical. At the time of operation the situation appeared quite hopeless and even then an attempt to carry out any form of palliation was considered only as an heroic measure. It has now been three and a half years since the implantation of radium and a cystoscopic examination one month ago revealed no evidence of tumor and the patient appears in excellent health. While no conclusions can be drawn as to the ultimate results in the above group of patients until after a five-year period has elapsed, the immediate results have thus far been encouraging.

It is quite true that these patients so treated with radium have had very severe cystitis, with often times great distress for many months. Such discomfort, however, is of little moment if the patient is afforded additional years of life. We have found that radium reaction is much less marked when radon seeds are used than when the filtered radium salt in removable needles is implanted. Our

results with the use of radium emanations has to date been very heartening and it is my prediction that the use of radium in the treatment of certain types of bladder cancer will undergo a revival in the time to come. The use of deep roentgen ray therapy for this disease has not been applied extensively enough in our patients to warrant an opinion. In the few cases in which it was used there was no evidence of change for the better. No criterion for cure by the use of radium has been established, but, as has been mentioned, some improvement in results seems to have been effected by its use in combination with surgery.

It is from these failures and apparent controls that we can begin to arrive at a far better understanding of the paramount necessity of doing much more in the way of radical surgery than was previously considered necessary than to err on the fatal side of doing too little. It appears quite obvious from our own observation and from the reports of others that the treatment of bladder cancer up until the last few years has been largely ineffective because of the failure to apply methods radical enough to eliminate the disease. In bladder cancer which has infiltrated deeply into the bladder wall, total cystectomy and diversion of the urinary stream is considered to be the method to which we can look with greatest hope of effecting a permanent cure. But to cure bladder cancer by total removal of the bladder, the status of the tumor as to its complete localization to and within the bladder must be reckoned with as the decisive factor relating to cure. The requirements to be satisfied for cure are that no tumor cells have spread beyond the bladder by means of the lymphatic or venous systems and that none shall have invaded the subvesical or preperitoneal fat and be left behind following bladder removal.

In so long as we reserve cystectomy for bladder cancer which has penetrated deeply or completely through the bladder wall, we must be mindful of the absolute necessity of removing the extravescical tissues directly adjacent to the tumor, be they subvesical or preperitoneal. To consider that the simple removal of the bladder, seminal vesicles and prostate, by whatever method (in cases of penetrating cancer), satisfies the requirements for cure, is false reasoning. Radical extirpation of the tumor process has forever been largely dependent upon the diversion of the urinary stream in such a manner as to be consistent with the maintenance of satisfactory renal function. The difficulties experienced in perfecting a satisfactory anastomosis between ureter and large bowel is well known to the surgical world and even unto this moment no method of uretero-intestinal anastomosis can be considered to be entirely dependable.

It is hoped that in due time some scheme may be devised whereby the risks of this most necessary procedure may be eliminated. Anastomosis of the ureters to the skin, while carrying definite disadvantages to the patient, is by far the safest of the two choices of diversion of the urinary stream.

The recent work of Brunschwig, of Memorial Hospital, in performing wet colostomies and removing in one block the pelvic genitourinary organs together with the rectum, is probably the nearest approach to complete removal of advanced cancer of the pelvis that has yet been proposed. But here again even this radical procedure is conditioned by the cancer being necessarily localized to the area with no invasion of the blood vascular system having taken place.

Only in the past 12 months both Colby and Leadbetter, of Boston, have proposed and reported extensive dissection and removal of the immediate lymph channels and nodes draining the bladder for advanced, deeply penetrating cancer. In Leadbetter's series of 12 patients, malignant cells were found in lymph nodes some distance from the bladder in 2 patients. It is not unlikely that these 2 patients might be cured by this extensive lymph adenectomy associated with removal of the bladder, prostate and seminal vesicles. Although such a surgical procedure might be considered to be quite drastic, it is to such pioneering plans of radical attack that we must pin our hopes for cure and for want of a better answer to the problem of malignancy, even more extensive surgery is no doubt yet to be proposed.

EXPLORATION OF THE COMMON BILE DUCT

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THIS is a paper on technic and method, an admittedly delicate and touchy aspect of any surgical problem. There are so many different viewpoints and technical variations; and each man, experienced and inexperienced surgeons alike, naturally thinks that the method he is using is the best. A paper on technic thus easily may be misinterpreted as one which, while presenting one method, is critical of others. At the outset, let it be definitely stated that there is no intention of standardizing methods of exploring the common bile duct by what is reported herein, nor are these views presented by the author with absolutely didactic insistence that they alone are the best.

There are so many different questions concerning the exploration of the common bile duct, about which there is not only a variety but also frequently a diversity of opinion. For example, there is the question whether or not one should use strong force in passing increasingly large graded dilators through the ampullary portion of the common bile duct; and the question whether or not the duodenum should be opened rarely, or commonly, or routinely; and third, the question whether or not after the common bile duct has been opened it should be intubated with a T tube or simply closed as advocated by such able surgeons as Reinhoff and others; and fourth, the question whether or not the T tube should, if placed, have a short transverse arm or a long arm extending through the papilla into the duodenum; fifth, the question of what is the cause of postcholecystectomy syndrome, whether it is due to biliary dyskinesia, or to retained stones, or to stricture of the ampulla. Moreover, these questions do not take into consideration the indications for opening the common bile duct during operations for benign disturbances of the biliary system. Certainly there is a great variation in the percentage of common duct explorations when cholecystectomy is being performed in different series of cases. In some measure, of course, indications are influenced by the ability of the surgeon performing the operations. This is true of almost any surgical procedure. The more experienced and more skillful surgeons are perhaps justified in extending the indications over and above those

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which are obviously absolute, and which probably may be the extent of indications for choledochostomy under less favorable conditions.

There are a number of different theories and undoubtedly a number of different causes for the formation of stones in the gallbladder. Undoubtedly, infection, metabolic disturbances, particularly of cholesterol, and stasis possibly due to aberrant vessels crossing the cystic duct or the kinks in the cystic ducts are all well known causes. On the other hand, the possibility that the cause of stones in the common bile duct may be due to stasis, the result of disturbed physiology or definite pathology in the region of the ampulla of Vater, is rarely recorded. I personally feel that in many instances where the stones exist in the gallbladder, and particularly where they are found in addition to that in the common bile duct, that the original cause of the trouble was not in the gallbladder but at the ampulla of Vater and that this cause may be demonstrated by direct visualization as a cicatricial stenosis in the papilla of Vater. Stenosis at the opening of the common bile duct into the duodenum is far more common than is generally realized. Mallet-Guy, of Lyon, deserves credit for his manometric and radiographic studies at the operating table, demonstrating that physiologic and pathologic changes at the lower end of the common bile duct are frequently the cause of "post-cholecystectomy syndrome." The problem of stenosis at the papilla of Vater may also be closely associated with the etiology of acute and subacute, and chronic pancreatitis. In 1909, Opie showed that bile shunted into the pancreatic duct may produce acute hemorrhagic pancreatitis. It is well known also that in many cases of acute hemorrhagic pancreatitis stones may be found in the gallbladder and sometimes in the common duct. In a high percentage of cases of acute pancreatitis, a history of sustained alcoholism may be obtained. Various other factors, even neurogenic, have been recorded as causative in pancreatitis, but one which I have not seen is that sustained alcoholism producing not only acute gastritis but acute duodenitis with swelling of the papilla of Vater may thus result in shunting of bile back into the pancreas. If this is true, the treatment of acute hemorrhagic pancreatitis should always be, if possible, intubation of the common bile duct, or decompression of the biliary tract at least by cholecystostomy. Moreover, transvaterian extension of a multiperforated tube may be more efficient in maintaining decompression and obviating the obstruction than a short arm tube in the supraduodenal portion of the duct.

In a series of 126 cases on our private services in which operations were performed for benign lesions involving the biliary tract, I have taken the attitude that when the common duct was opened, that not only would it be incised in its supraduodenal portion but in

a high percentage of the cases the duodenum should be opened at the same time, giving free access by visualization and direct palpation to the papilla of Vater and the lower paraduodenal portion of the common bile duct. In the 126 cases, cholecystectomy was performed without choledochotomy in 94. So far as I know, none of these 94 patients has developed symptoms postoperatively, which makes us regret not having explored the common duct. One of these patients died, a woman aged 80, who had a recurrent severe acute cholecystitis.

The common duct was opened in 34 cases, or 27 per cent of the total. This is not a high incidence of duct explorations, but approximately one in four operations involved opening of the duct and only two instances of these yielded negative results. The approach to the greatest accuracy is avoiding failure to explore the duct where it is indicated, resulting in postoperative signs suggesting obstruction; and, on the other hand, avoiding exploration when it is not indicated, which done, would yield negative results but slightly increases the risk. I have an idea that the optimum judgment will lead one to explore the duct in not under 22 and not over 35 per cent of any group of cases.

TABLE I
Operations on the Biliary Tract. Summary

Cases	126
Cholecystectomy only (Death 1, age 80).....	92
Exploration and intubation of the common bile duct: 27%....	34
(Death 1, duodenum not opened)	
Exploration common bile duct and cholecystectomy.....	30
Exploration and intubation duct without cholecystectomy.....	4
(Gastrectomy 2)	
(Pancreatitis 1)	
(Duodenal diverticulum 1)	

In the 34 cases in which the common duct was explored, the duodenum was opened at the same time in 23, or two-thirds of the cases. All of these patients with combined supraduodenal and transduodenal exposures have recovered. Only 1 of the 34 operations in which the common duct was open resulted in a fatality, and that when the common duct above the duodenum was incised and the duodenum was not opened. That statement is made to show that in our hands duodenotomy has not added appreciable risk to the operation. However, it is not entirely safe. Unofficial information has reached us that in two hospitals in New Orleans tragedies have occurred when men attempted this type of operation—tragedies in the shape of duodenal fistula and even in common duct stricture.

We believe these complications are unnecessary and that they can be avoided. It stands to reason that any operation involving exploration of the common bile duct is a serious one, and that it should be, if possible, in the hands of an experienced surgeon or if not so should be under proper supervision. It should not be undertaken lightly; and unless technic is most carefully accomplished, the older method of exploring the common duct should be adhered to. I do not want the responsibility of advocating an operation which will spread disaster to many patients. Of course, in defense of the operation itself—it can be accomplished with security, and I believe that it has many advantages in certain circumstances.

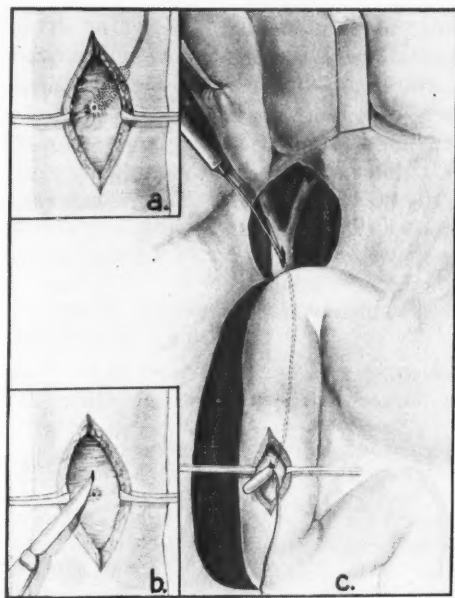


Fig. 1

Figs. 1 and 2. Method of obtaining detailed information about the lower end of the common bile duct by combined supraduodenal and transduodenal exploration and visualization. In 4 of the 24 instances in which the duodenum was opened, it was found that the probe had failed to pass through a stenosed opening in the papilla of Vater. Palpation of the probe along the parapancreatic portion of the duct and direct visualization of the papilla will often give information concerning obstructive lesions at the lower end of the common duct. Ampullotomy, as indicated, was necessary in several of our cases. A guide string, drawn through the duct by the Bakés dilator, will facilitate intubation of the common duct.

Combined supraduodenal and transduodenal exploration of the common bile duct has taught us that in many instances we, at least,

and probably many other surgeons, are fooling ourselves when we think that a Bakês dilator passed from a supraduodenal opening in the common bile duct has traversed the papilla of Vater into the duodenum. In four instances, with the assistants agreeing after palpating the end of the sound, it has given us the impression that it was through the papilla of Vater. After opening the duodenum, we found that it was simply displacing the papilla of Vater before it, and that a stenosis or possibly a tight contracture of the sphincter had prevented it from going beyond that point. In 7 instances out of 23 in which the duodenum was opened, we found definite stenosis of the ampulla of Vater requiring a milking action or an actual ampullectomy to get a small sound through. In two of these instances,

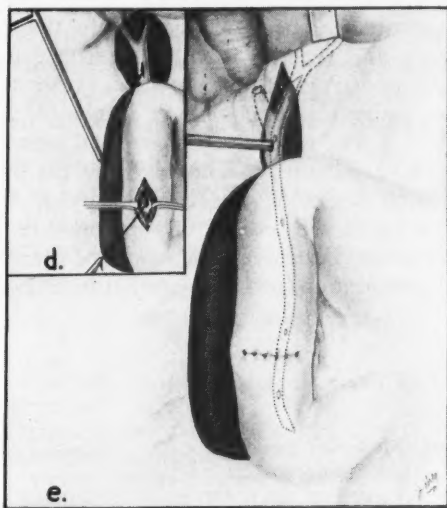


Fig. 2

In Figure 2, a long arm T tube has been drawn through the common bile duct, into the duodenum. The opening in the duodenum must be closed most carefully and most securely. No mortality has resulted following this approach in our hands, but its dangers must be acknowledged and are discussed in the text.

stones were still in the common duct, but from the appearance the stone could not possibly pass because of a stenosis of the opening of the common duct at the papilla. In at least 6 cases, after opening the duodenum we have taken additional stones out of the common duct from below. In one instance, we found an ulcer of the duodenum which proved to be benign but which involved the papilla in a regional inflammatory reaction. In another instance not included in this group of cases (because it was a malignancy), we

removed stones from a hugely dilated common bile duct which had been operated upon twice before within three years prior to his coming under our care at one of the renowned institutions in this country by a well-known surgeon. We opened the duodenum and found a papilloma of the papilla of Vater through which passed the attenuated common bile duct. Each time he had been operated upon previously, the stones had been removed and a short arm T tube had been inserted into the common duct; and the man had remained free of jaundice as long as the common duct tube was left in. When it was removed, his jaundice recurred. At the operation we performed, the stones were removed from the common bile duct, the duodenum was opened, and the papilloma, ultimately pronounced malignant, was excised. We transected the common duct in its retroduodenal portion and reimplanted it into the duodenum. A gastroenterostomy and seeding with radon in the intrapancreatic portion of the duct was accomplished at a later operation. The man was permitted to retain the common duct T tube for a period of six months, and then it was removed. There has been no recurrence of jaundice for a period of 18 months. Whereas pancreatectomy may have been more desirable, we felt in this instance after a series of operations and with the patient in very poor condition that it would have been a choice of poor judgment; the present appearance of the patient 18 months following operation justifies our decision.

TABLE II
Exploration Common Bile Duct. Summary

Cases	34
Duct explored, duodenum opened.....	24
Duct explored, duodenum not opened.....	10
(Death 1, duodenum not opened)	
Cholelithiasis	19
Stenosis	5
Negative findings	2
Gastrectomy (Intubation common duct).....	2
Diverticula duodenum removed	1
Pancreatitis	3

In only two instances in the entire group were negative findings recorded. In 26 instances, exploration revealed either stones in the common bile duct or stenosis at the ampulla of Vater. In two instances, the common bile duct was intubated because in doing a gastrectomy for duodenal ulcer it had perforated onto the head of the pancreas. We were so close to the bile duct that it was felt that intubation was a safer method of protecting the duct. In three instances in this series, the common bile duct was intubated because

of pancreatitis; these 3 patients recovered. In two instances, the common bile duct was intubated at the same time a duodenal diverticulum was excised. One of these diverticula was in the second portion of the duodenum near the opening of the duct, and intubation was mandatory. In the other patient who had had a cholecystectomy performed elsewhere, there was a residual portion of a gallbladder left in. The duodenal diverticulum was removed from the third portion of the duodenum. The ampullary portion of the gallbladder was excised, and the common duct, in order to make sure, was explored and a T tube inserted.

Stones were found in the common duct in only 19 of the 34 cases. If one excludes the 3 cases in which the common duct was intubated because of pancreatitis, and the 2 cases it was intubated at the time of gastrectomy, and the 1 case when it was intubated because of a contiguous duodenal diverticulum, stones would have been found in approximately 73 per cent of explorations. On the other hand, stenosis without stones was found in five instances.

Jaundice was present in 21 of the patients. Jaundice was present without stones in 5 of the patients; and in one of these pancreatitis was the cause of the obstruction. In 4 others, stenosis was the factor. Stones were present in the common duct without jaundice being manifest in 4 patients.

TABLE III
Exploration Common Bile Duct. Summary

Cases	34
Jaundiced	21
Stones, common duct	19
Jaundice, no stones (Pancreatitis 1).....	5
Stones, no jaundice.....	4
Stenoses, no stones.....	5
T tube extended into duodenum.....	24

The T tube was extended into the duodenum in 24 patients. We rather like this method of draining the common bile duct. We have learned that duodenal reflux is not nearly as dangerous as the older literature would regard it. We do not hesitate to cut the ampulla of Vater, which was done in a few cases. In most of the other instances, the lower end of the common duct was dilated with Bakés dilators, and after opening the duodenum and tying a silk guide onto the end of the Bakés dilators it was retracted through the opening in the supraduodenal portion of the duct. After attaching this to the lower end of a long arm (Cattell) T tube, the tube was pulled into the duodenum. I prefer extending the T tube into the duodenum

because I am firmly convinced that much of the pathology existing in the gallbladder and the common duct in these cases is due to disturbances at the lower end of the common duct—either dyskinesia, or stenosis, or stones. If a stenosis is present after dilatation or ampullotomy, the insertion of a T tube into the common duct and extending it into the duodenum I feel, if left there for a period of six to twelve weeks, will prevent the recurrence of a stenosis. If there has been any evidence of stenosis at the lower end of the duct, we leave a tube a minimum of four to six weeks.

With regard to technic, here are a few points which I believe are absolutely essential for safety in this type of operation. The duodenum must be mobilized. For some reason or other, many resi-

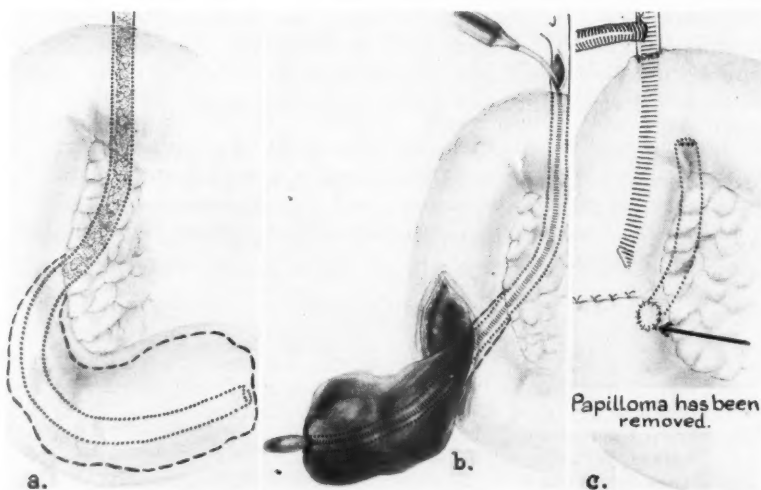


Fig. 3

Fig. 3 a, b, and c. Illustrate conditions found in the patient cited in the text. Twice within the three year period prior to coming under our care, stones had been removed from the common bile duct. Each time the common duct T tube had been withdrawn the patient became jaundiced again. At the operation we performed numerous stones and mud were found in the common bile duct. On opening the duodenum, a large papilloma of the papilla of Vater was found, and through it passed an attenuated and compressed bile passage. The papilloma was removed; the common duct was transected, and the proximal portion reimplanted into the superior surface of the duodenum. At a subsequent operation, a gastroenterostomy was made and the region of the residual portion of the common duct was "seeded" with radon. The patient has gained weight and has been free of jaundice for 18 months.

dents and doctors have the idea that the duodenum is a retroperitoneal organ and that the posterior surface of it is uncovered by peritoneum. This is far from accurate. The duodenum is covered

by peritoneum on all sides except at its pancreatic surface, and there also is an original peritoneal covering which becomes attenuated because of its juxtaposition with the pancreas. On the posterior surface it is as well peritonealized as on the anterior. There is a fold of peritoneum extending halfway up the duodenum from the superior leaf of the transverse mesocolon. In exploring the duodenal portion of the common bile duct transduodenally, it is necessary to incise this fold and push it down. One will be surprised how much duodenum lies under the superior leaf of the transverse mesocolon. In addition to that, there is a fold of peritoneum extending from the right surface of the duodenum on to the posterior parietal peritoneum. It is necessary to incise this to elevate the duodenum. It should be elevated from its superior arch down past the middle to the lower portion. When this is accomplished, the surgeon may put his hands behind the pancreas and behind the duodenum. The duodenum and pancreas are turned forward. Then with a probe in the common bile duct through a supraduodenal opening one can manipulate anteriorly and posteriorly and palpate carefully and feel along the probe. The duodenum may be opened just below the middle of its extent but under the original superior leaf of the transverse mesocolon. The pressure of the probe will serve as a guide to the ampulla of Vater. I usually make the incision longitudinal, into the duodenum on its anterolateral aspect. Then the probe may direct the papilla of Vater into the opening, and it may be clearly visualized and clearly palpated. In this way, how often, if surgeons are careful, will they find that a papilloma or a small neoplasm at the papilla is the cause of symptoms justifying their exploration of the common bile duct. Undoubtedly, in the future many patients will be saved by such direct exposure. After the sound is pushed through the papilla of Vater, additional stones disengaged, and if necessary, after an ampullotomy has been accomplished and all evidences of stones have been cleared, the duodenum may then be closed most carefully and most meticulously. It is better to close the wound in the duodenum transversely. I prefer a running 00 chromic catgut suture for the inner layer, reinforced by interrupted silk stitches. It is absolutely important for complete secure closure to be accomplished since any extrusion or protrusion of the mucosa may lead to a disastrous complication.

How often the duodenum should be opened in exploring the common duct I am not prepared to say at the present. I will admit that my present series of cases represents, to a certain extent, investigation as to the best technical method of approaching benign obstruction to the common bile duct. If a probe passes freely into the duodenum without any evidence of obstruction whatsoever, it may

not be necessary to open the duodenum. One may be absolutely sure in certain cases that the probe is into the duodenum. On the other hand, there may be cases in which its passage is doubtful and others in which it cannot be passed. In two instances, we penetrated the common duct with small probes while being unable to pass it through into the duodenum. In one of these, stenosis only was present; in the other an impacted stone. I have an idea that surgeons have been fooling themselves in very many cases, and that therein is the explanation for much of the postcholecystectomy-postcommon-duct-exploration syndrome; that many of the cases with recurrent attacks of pain still have obstruction, either of a benign cicatricial character or due to small stones. It is my impression that if surgeons open the duodenum more frequently and carefully explore the lower end of the common duct and the papilla of Vater, they will frequently find pathology which they did not suspect was present. Perhaps the duodenum should be opened in at least one-third of the cases where the common duct is opened. It is only by repeated open discussion of such difficult technical problems as this involves that surgeons will finally summarize in the light of every one's experience the best possible method of exploring the common bile duct and of obviating the obstructions which necessitate such operations.

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SOME FURTHER CONSIDERATIONS IN THE TREATMENT OF SURFACE CANCER

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New Orleans, La.

ONE of the important aspects in the consideration of treatment of surface cancer is that all cancers in this category are entirely visible to the patient as well as to the physician and are, therefore, amenable to the earliest possible diagnosis. It is this fact which has so vividly impressed the importance of educational programs. Much good has resulted from educational campaigns in stimulating the interest of the patient and as a result many early cancers have been diagnosed at a stage when cure could be offered. Perhaps equally important is the patient with a precancerous lesion, almost invariably small and discrete, who by seeking advice from his physician at an early stage is able to avoid the development of cancer. Frequently precancerous lesions may be adequately cared for through instruction to the patient relative to the proper care of the part. There are certain lesions which are known to mutate into cancer that may be adequately controlled through hygienic measures, such as proper cleansing of the area with non-irritating types of soap, in association with daily applications of bland cold creams. This simple regime may prevent the development of cancer in many of these early growths.

One of the great concerns of a patient is related to the cause of cancer. Many individuals are confused because of stories concerning cancer which have suggested that the disease is inherited or that it may be the result of a daily habit, or equally related to a dietary regime. Because of this confusion, frustration frequently results from the thought that a possible incurable malignancy exists. Much of this needless concern may be avoided through the dissemination of proper information from the medical profession to the lay public. Such programs have been offered the public for years through various national and local organizations with results that have been highly satisfactory. These programs, like so many others, however, in the dissemination of proper knowledge to individuals, should be perennial in order to keep the interest of the individual in his personal well being active. In this manner a given individual is less likely to permit an early sign or certain warning to go unheeded or to procrastinate in soliciting adequate attention.

Prophylactic care of the skin. Treatment of surface cancer may logically include that group of patients whose lesions are entirely benign or definitely precancerous, and which may be adequately treated through prophylactic measures. One finds a relatively large number of individuals who are indifferent to the proper hygienic care of the skin and frequently added to this is the irritation from chronic exposure to the actinic rays of the sun. In the deep south ample evidence is afforded that chronic irritation plays a part in the production of skin cancers, for great numbers of individuals who constantly subject the exposed parts of their bodies to the rays of the sun over longer periods throughout the year, show a higher incidence of skin cancer. Because of this a high percentage of precancerous or early cancerous lesions are noted. These are seen as areas of dryness, encrustations, hyperkeratoses or areas of irritation along the vermilion border of the lip, which produce an abnormal thickening associated with scaliness, fissures and chronic ulcerations. A considerable number of these precancerous lesions may be adequately cared for by frequent cleansing of the skin with mild, non-irritating soap, using copious quantities of water and followed by the application of U.S.P. cold cream three or four times daily. The precaution of protecting the skin of a patient, who is predisposed to the development of these lesions, by wearing a hat which will shade the face or gloves to protect the hands, is obvious. These measures may prevent the development of precancerous lesions if properly followed. As proof of the value of these suggestions one only has to consider the relatively small number of precancerous or cancerous lesions on the face and hands of beautiful women. The obvious reason for this is the continuous and unusual care which the average woman gives to her skin through frequent cleansing, massage and lavish applications of various types of facial creams. This regime unquestionably reduces to a minimum the number of skin lesions over the exposed parts of the body.

If a patient follows advice relative to proper hygienic care of the skin along with diligent applications of cold cream and precancerous lesions fail to show a regression or fail to disappear one should consider surgical excision of the area in question. Certainly if an area of hyperkeratosis has reached the stage where scaling occurs or has occurred for some time and is occasionally associated with chronic irritation and bleeding, one should seriously consider the possibility of immediate surgical excision and biopsy. It is well to remember that many early skin cancers are so innocent in their appearance as to cause minimal suspicion on the part of the physician, to say nothing of failing to cause any great concern on the part of the patient. Not infrequently are innocent looking areas

removed and biopsied, more with the thought of prophylactic treatment than for the cure of cancer, only to find at biopsy that the growth has progressed to a stage of early cancer. It is in this group where so much good can be done with so little surgery.

Another group of patients present far advanced precancerous growths, showing a progressive increase in the size of the original lesion, a marked scaling associated with occasional ulceration or a progressive elevation of the lesion concurrent with its growth. These should be regarded as potentially malignant and comprise a group of neoplasia demanding excision and biopsy. Consideration of treatment of a new growth, whether it be early cancer, borderline cancer or advanced cancer, entails an appraisal of various methods of treatment and selection of the best method for the particular lesion. Frequently one hears advice suggesting that these lesions should be treated by some type of radiation. No attempt will be made to go into detailed discussion regarding the properties of x-ray or radium or to evaluate indications for specific tumors. It is felt that there are certain fundamental problems which should be evaluated when appraising these growths in terms of treatment and fundamentals which should be strictly adhered to regardless of the type treatment suggested. There are certain neoplasia which we know to be responsive to radiation. To say that all lesions which respond are permanently cured is questionable. To ignore possible undesirable sequelae that may arise as the result of radiation is to close one's eyes to a future complication that might well result in a serious condition at some time in the future. It is well to remember that there are many lesions which do not respond to radiation and yet patients are frequently seen who have had radiation applied to such areas with untoward results. There is still another group of lesions which we know to be in a class which does not respond to radiation and further, that radiation is definitely contraindicated. Naturally there is little excuse for the application of radiation in this latter group. Suffice it to say that in the event one desires to advise radiation as a method of treatment for any of these lesions there are certain fundamental procedures which should be carried out before this decision is made. Proper treatment of any skin cancer implies a microscopic study of that lesion which can only be done by means of a biopsy from the tissue removed by surgical excision. There is little if ever any excuse for this fundamental procedure to be overlooked. It is known too that advice relative to radiation of a given lesion can best be given after an evaluation has been made by a competent pathologist, who studies the microscopic sections from a biopsy of this lesion. In this manner one can obtain necessary information regarding whether or not a growth will respond

to radiation and in a large degree obtain suggestions relative to the technic of application and the amount to be applied. There is little excuse for one to advise dogmatically the application of radiation in the treatment of a lesion when the decision has been made purely on the basis of clinical appearance. All too often we find patients who have been treated by radiation where the proof of malignancy has not been established and in like manner where there has been no attempt to classify properly the tumor in question. One frequently sees a tumor which has all appearance of the typical picture of a basal cell carcinoma which on microscopic study is proven to be a squamous cell carcinoma and vice versa.

One may rationalize treatment on the basis that it perhaps makes little difference whether a given tumor is basal cell carcinoma or squamous cell carcinoma, but I contend that this type of rationalization is questionable. There are many pertinent considerations which one should keep in mind in presuming to treat squamous cell carcinoma which would be of less concern if one knew that the lesion in question was basal cell carcinoma. First among these would be the question of possible treatment or surgical excision of neighboring lymph nodes. It is not implied that one should seriously consider the excision of all local lymph nodes in cases of proven squamous cell carcinoma but certainly the possibility should be always considered and properly evaluated. Another fallacy which seems to be commonly accepted is the feeling of security, that because one has a basal cell carcinoma one has little cause to worry about the ultimate outcome regardless of treatment offered. On close study and observation, based on frequent follow-up examinations over long periods of time, one is prone to wonder whether a basal cell carcinoma, particularly if it is widespread or invasive, is not more difficult to completely eradicate locally than the squamous cell variety. This surmise is supported by the respect which such astute and widely known pathologists as Bloodgood and Ewing have expressed. If this rationalization is correct one may say, after proper study, evaluation and classification of tumors, that: there is a group which may be adequately treated either by radiation or by surgical excision; there is a group which should be treated by surgical excision in combination with radiation; and, there is another group where radiation is positively contraindicated.

If proper treatment, whether by radiation or surgery, implies that a microscopic study of a surgical biopsy of the tumor in question be done by a competent pathologist, one should immediately be impressed with the thought that a large number, if not all, small, discrete neoplasia, whether they be precancerous or early cancer,

could be and should be adequately extirpated by surgery at the time the biopsy is taken. Since little more tissue is required for complete surgical removal than would be required for a biopsy and there is no more disturbance to the patient in the removal of this tissue, I see no reason why there should ever be question as to the advisability of adequately removing these lesions surgically when biopsy is done. If this procedure is followed the patient is subjected to only one course of treatment—surgical excision at the time of biopsy. Microscopic study is made immediately after removal of tissue and pertinent information is rendered the surgeon within three to five minutes after the lesion has been removed. This information imparts to the surgeon the diagnosis of tissue removed and whether the margins and depth of the remaining defect are completely free of further tumor invasion. The surgeon may then close the wound with minimal disturbance to the patient and obtain a satisfactory result through healing which shows minimal scar and distortion. The patient's period of incapacity will be reduced to the smallest possible time. All of these considerations are pertinent to the patient, and proper performance of these by the surgeon guarantees him the best result with a minimum of discomfort, treatment time, disability, hospitalization and loss of manpower hours.

If one desires to suggest that a given lesion should be treated by radiation, proper performance would entail an initial surgical procedure for biopsy followed by a microscopic study of this tissue by a pathologist, before being able to establish information necessary to advise that the growth could be adequately treated by radiation. Subsequent to the surgery necessary for biopsy the patient would have to report for the applications of x-ray or radium over the period indicated and await for the radiated tissues to adjust subsequent to its application. It therefore appears that much radiation is unnecessary in these cases, if surgical excision with cure can be done in association with the biopsy with little more loss of tissue or discomfort to the patient. If surgical excision, adequate for cure of a given lesion, has been performed, then any further treatment, whether it be radiation or other types, is unnecessary. If one properly considered the patient's welfare, one would have to consider the possible changes that might develop at a date subsequent to the application of radiation. All too frequently one sees lesions at sites which were formerly radiated with presumptive cure of the original growth, which are found to be malignant. Cancer arising at such sites manifests itself as squamous cell carcinoma.

If one elects to treat a given lesion, whether precancerous or cancerous, by surgery, one should assume that proper surgical care entails complete and adequate extirpation of all tumor tissue.

Microscopic studies of the initial surgical biopsy should reveal that the resulting defect is free of any evidence of residual tumor tissue. This can only be accomplished by a study of serial biopsies, the pathologist checking the microscopic sections around the margins of the defect and tissue from its depth. When a competent pathologist reports these free of all evidence of tumor tissue, one can assume that a lesion has been adequately removed and that there should be no recurrence, with the possible exception that nests of tumor cells may have been swept to remote parts by the blood stream or through a lymph channel or that some microscopic nest of cancer cells had been overlooked in the microscopic study. Surgical excision of cancer should be carried out with the sole thought of complete eradication of the lesion in question and the surgeon's sole aim should be complete cure from the invasion of the lesion. In order to fulfill the above obligations one cannot compromise surgical excision in terms of subsequent repair. A competent cancer surgeon cannot let himself be concerned with resulting defects, lest on occasion he be tempted to compromise the necessary excision of tissue and in so doing have the patient present evidence of residual cancer subsequent to initial removal.

After cancer has been properly excised a survey should be made to appraise the repair of the defect. In extensive lesions of cancer, it is frequently necessary to extirpate so widely and deeply as to make immediate repair of the defect impossible. In instances where there has been extensive invasion it is frequently necessary to cauterize the entire surface of the residual defect by actual cautery. This is particularly true if cancer has invaded the periosteum and the underlying bone, for one can only attempt to destroy these tumor cells by actual cauterization of the bone surface; unless, of course, one chooses to completely excise the bone. Following the actual cauterization of the periosteum and the bone, a sequestration of the outer table of cancellous bone occurs, thus accomplishing the destruction of the invading tumor cells in this structure. Where a defect is massive and the required repair great, one chooses to delay extensive reconstruction for a minimal length of time. Theoretically one should wait for a period of five years but patients are unwilling to accept this length of delay before being offered coverage of their defects. We as a rule delay repair of these defects for a period of approximately one year, although some surgeons doing extensive cancer excisions compromise by offering repair at a sooner period than this. I personally feel that one year is the shortest time that one can safely presume to proceed with any extensive reparative work.

In instances where a defect from cancer excision is relatively

large but not sufficiently large to make repair impossible at that stage, initial reconstruction should be done either by the application of a skin graft or more preferably by swinging a single pedicle skin transplant from adjacent skin into the defect. The latter type of repair is much more satisfactory in that the survival of tissue is almost always assured and the quality, color, and texture of the tissue used in the repair is identical with the skin removed in the production of the defect. Cosmetic appearance following repair of defects is highly important to patients. In contrast a lesion repaired by surface coverage with skin graft would show skin of different texture and color, thus producing a compromise with which the patient could only be unhappy.

The postoperative care of a patient entails the care indicated in terms of the surgical manipulation required. In a small, discrete, local lesion, one can usually excise adequately with local anesthesia and closure of the resulting defect can satisfactorily be accomplished by direct approximation of the defect margins, having the patient remain ambulatory throughout the entire course of treatment. In more extensive cases, where skin grafting or flap formations are required, one has to hospitalize the patient for an adequate period of time, varying from one to two weeks. Of course, before and after surgery competent study should be made to assure the patient's physical status to be such as to permit him to undergo the operation and special attention should be directed towards the state of his nutrition and blood picture. All efforts should be made to see that these patients have a blood count which is normal or slightly above, with hematocrit and hemoglobin appraised at a high level. Adequate fluid intake should be assured these patients and a nutritious diet carrying at least 300 to 350 Gm. of protein daily along with adequate amounts of carbohydrates and fat. Any question relative to the intake should be clarified by a close surveillance by the nurse and by having the dietician weigh the food presented and weigh the food brought from the patient's bedside.

TREATMENT OF SPECIFIC LESIONS

Warts. Warts are regarded as one of the most benign of all neoplasia. Various suggestions for the treatment of these growths have been made. Ordinarily they are sufficiently discrete as to make their treatment relatively simple, but there are occasions where, because of their location and size, treatment becomes quite difficult. They can be trying problems when located on the tips of fingers, particularly if they are located at the margins and extend beneath the finger nail. The same situation applies to the toe. One of the most trying problems a surgeon may be called upon to treat is that

of the plantar wart, for these are seldom small and discrete and are usually widespread, covering large portions of the sole of the involved foot. Surgical excision of all of these immediately becomes an extensive problem, yet if their number is sufficient to demand complete excision of all skin over the plantar surface of the foot, this can be done with less difficulty and subsequent complication than the average case will show if treated with radiation. I have seen many extensive cases which have been treated by radiation with only the bad result of incomplete cure associated with radiodermatitis and necrosis sufficient to be crippling to the patient. Where this type of complication exists only complete surgical excision of the involved radiated skin followed by surface covering either of a skin graft or some type of pedicle must follow sooner or later. If delay in the removal of this radiated skin is postponed too long, there is always the possibility of malignancy developing in the altered tissues. Perhaps surgical excision of all discrete warts of modest size is the ideal treatment. This should be followed by closure effected by approximation of the defect margins. In proximity to a fingernail, the flexor crease of a finger, or similar areas surgical excision associated with skin graft or an adjacent single pedicle flap is frequently indicated. As regards plantar warts, treatment here should first be directed towards palliation and care towards cleanliness, removal of any undue pressure or irritating points that may be transmitted from a shoe. If these palliative measures fail to aid in the cure of these plantar warts and they show progressive growth, I feel that surgical excision followed by a graft or pedicle transplant is the method of choice.

Keratosis. These particular lesions, whether hyperkeratoses or the senile keratoses, are more frequently found over the exposed areas of skin covering the forehead, nose, face, ears, neck and hands. They are commonly associated with chronic irritation and not infrequently their size and mutation is in proportion to the lack of hygienic care of the skin and chronic irritation from sun, wind and weather exposure. Initial treatment should suggest palliative measures, such as frequent cleansing of the skin with a non-irritating type of soap, along with the application of U.S.P. cold cream for a minimum of three to four times daily. I have seen many early lesions completely disappear under such regime and others held in essentially the same early state as when first seen. If under observation this type of treatment fails to show satisfactory response after a period of two to three months, and particularly if there is evidence of progression and growth, one should surgically excise the lesion. At this stage essentially all of these can be removed surgically in a very simple manner and the defects closed by direct

approximation of defect margins. The excised tissue should be examined microscopically for not infrequently lesions which appear benign, clinically, prove to be early basal cell carcinoma. Predisposition seems to play some part in the development of keratoses and where this seems to be a factor, one should warn the patient that subsequent development of this lesion is likely to recur and for this reason careful survey of the skin should be frequently made.

Cysts. These tumors develop from the retention of products resulting from the activity of their functioning component structures. The retention is effected by a definite cystic wall which varies in size and thickness, usually becoming thinner and less stable in direct proportion to the expansion and size of the cyst. Almost invariably it is good judgment to advise surgical excision of any cyst as soon as the diagnosis is made. Nothing is to be gained by aspiration or incision of these except a temporary reduction in size and frequently an associated infection. Procrastination in removing cysts frequently means that the surgical procedure is more difficult and complicated as the result of unnecessary scar and involvement of the surrounding skin covering. Not infrequently this delay permits sufficient thinning of the skin at the site of the cyst as to make it impossible to remove without excising a portion of skin as well. Early excision frequently avoids this. Most of these tumors are presumed to be benign and relatively innocent in so far as malignant activity is concerned, but here again with additional knowledge from accumulated statistics it has been found that they are not as innocent as once thought. Within the past two years, I have treated 2 patients with extensive cancer arising from a sebaceous cyst, presumptively the most innocent of all cysts.

Moles. Moles are tumors arising from the skin, usually small and discrete, although they vary considerably in size; they may be pigmented or non-pigmented and may be pedunculated or non-pedunculated. They are composed of nevus cells and show a characteristic type of growth. Since they are commonly small and discrete, surgical excision is usually the best method of treatment. This is particularly true when one considers that this method permits closure of defects by direct approximation of the defect margins with a resulting minimal scar. The correctness of this decision becomes more obvious when one considers the potentiality of this specific tumor to occasionally mutate into a vicious type of malignancy under conditions of trauma. Many cases have been seen which from history revealed that the initial growth on investigation proved to be a malignant melanoma initiated from trauma such as the application of chemical caustics, electric desiccation, radiation or inadequate surgical removal. Many others, from history, mu-

tated into a malignant melanoma as a result of trauma from shoes, irritation from belts, hat bands or clothing covering any part of the body which might serve to chronically irritate the growth. It is felt by some pathologists that certain types of moles are more prone to undergo changes than others. The bluish-black moles seem to be more prone to develop this type of mutation than the black types. It is known, however, that non-pigmented moles can produce cancer which is just as vicious as that seen in the pigmented types. In instances where malignancy arises within the substance of a pigmented mole an extremely malignant type of growth occurs, which offers poor prognosis in so far as cure. All too frequently generalized metastasis occurs very early and it is not uncommon to see a patient die from this condition within one or two years after the initial growth has been observed. In other instances where the malignancy, from a microscopic study, appears to be one of low-grade, one, by closely observing such a patient and surgically extirpating the localized metastases as they become manifest, may enable this patient to enjoy a relatively normal life for a period of 5 to 10 years. One must always consider the possible urgency of doing a radical resection of the neighboring nodes when diagnosis of malignant melanoma has been made. One patient under treatment at present time developed a malignant melanoma in the substance of the skin of the back, in the region of the left posterior axillary line, about the mid-portion. One would normally have considered the resection of the lymph nodes in the left axilla, but this was deferred. Approximately two years later palpable metastases were evident in the right axilla, proven following dissection. Subsequent to this a localized metastatic area appeared over the anterior aspect of the right leg just below the patella and this was surgically extirpated. Eleven months later a mass was noted which involved the sixth rib in the mid-axillary line which proved to be an area of metastasis subsequent to excision of the chest wall and pleura. The area was surgically excised, necessitating the removal of a portion of the fifth, sixth, seventh and eighth ribs, along with the intercostal muscles and underlying pleura. All apparent melanoma was removed but the resulting defect was such as to require the formation of a massive viscer skin flap from the tissues below, which was satisfactorily brought up to adequately repair the opening in the chest wall. This procedure served to protect the exposed lung and the patient showed satisfactory recovery, with minimal paradoxical respiration, in a very short time. Should these metastases appear in organs such as liver, brain or heart the hopelessness of the case becomes obvious. It behooves us on the basis of present knowledge to impress patients with the importance of eliminating questionable moles, par-

ticularly if they are situated in areas of the body which may be subjected to chronic irritation. I feel that moles on any part of the foot are a distinct hazard and should be immediately excised. Moles on other parts of the body become dangerous in direct proportion to the chronicity of irritation.

Cancer of mouth. Lesions which involve the mouth and buccal cavity are completely accessible to visual examination and should lend themselves to early diagnosis. This implies, of course, that the patient is conscious of the possibility of the presence of abnormal growths in these locations and is sufficiently interested to present himself for periodic examinations. If this regime is followed there is little excuse for late complications to develop because early diagnosis has not been made. The patient should be impressed with the importance of frequent and regular examinations by his dentist and of demanding a thorough examination or investigation of any abnormal findings.

Hyperkeratosis of the lip. One of the common early changes noted which involves the tissues of the mouth is that involving the vermilion border on the upper or lower lip, manifesting itself as a severe dryness with evidence of scaling and not infrequently associated with small ulcers or fissures. Microscopic sections of these areas reveal either a marked degree of thickening of the mucosa, which may or may not be associated with ulceration and chronic infection, or hyperkeratosis with early squamous cell carcinoma. This condition is directly associated with chronic irritation which may be from exposure or irritation such as one sees in pipe smokers. These changes are definitely precancerous and because of the relatively high percentage of these cases revealing a malignant state, active treatment should be initiated which is directed toward palliative treatment. One should advise the patient to keep liberal quantities of cold cream over the dry vermilion surfaces and avoid all types of irritation and exposure. If within a short period, one to two months, definite improvement is not noted, one should seriously consider surgical intervention. These areas can be completely excised in a simple fashion by surgically removing the involved mucosa of the vermilion border across the entire width of the lip. Even though the defect appears quite large and extensive, closure can easily be accomplished by bringing the margin of the mucosa on the inside of the lip, forward, to become attached to the skin margin of the defect. This closure is able to be effected with little difficulty and within two to three weeks there is little visible evidence of the operation. This simple procedure may be carried out on either the upper or lower lip and leaves a minimal disturbance in the cosmetic appearance of the lip.

Leukoplakia. This condition is seen not infrequently in patients showing chronic irritation of the lip, buccal mucosa, or mucosa over the alveolar margins. It is commonly associated with irritations such as seen in pipe smokers, individuals who are chronic tobacco chewers or snuff dippers, from ill-fitting dentures, jagged teeth or other sources of trauma. It may be associated as a complicating factor with luetic lesions. This is one of the lesions where radiation is contraindicated for this treatment not only does not cure but is likely to sufficiently irritate the already altered tissues to cause the development of squamous cell carcinoma in the area so treated. We have seen a number of these cases which have been treated by radiation and in practically every instance when an appreciable amount of radiation has been applied, squamous cell carcinoma existed. One can initially treat these lesions, unless obvious malignancy exists, best by palliative methods, paying particular attention toward the removal of any irritating foci. Corrective dental measures to accomplish this should be carried out immediately. It is well to insist that these patients refrain from the use of tobacco in any form during this period. Another pertinent consideration is that of eliminating constipation, which is fairly common in these patients. In the event these measures fail to show a regression, or certainly if the growth continues, radical treatment is to be considered. If treatment other than prophylactic measures is necessary, I feel that surgical excision followed by the application of a skin graft is the method of choice. A method of treating these lesions by the application of cautery is fairly popular, but here again I question the advisability of such procedure. Cauterization may or may not completely eradicate the leukoplakia, but even if apparent cure is accomplished by this method, I feel that the probability of a malignancy developing the resulting scar is increased. I have seen patients who have received this type of treatment without a cure being effected. Surgical excision is a relatively simple means of eradicating these growths and even in the deep recesses of the mouth over the buccal mucosa, the alveolar ridge or portions of the tongue, it is possible to surgically eradicate them and repair the defects immediately by the applications of skin grafts. This insures complete removal of the growth and the resulting cure is highly satisfactory.

Osteoma. Occasionally one finds a small, hard, nodular, hemispherical growth situated along the alveolar margin, or as not infrequently occurs, along the midline of the hard palate. These are firm in consistency and immovable and very hard on palpation. A history of slow growth is usually elicited. Where they are found, one can almost invariably diagnose them as osteomas before surgically exposing them or before a microscopic study has been made.

They are almost invariably benign and surgical excision is the treatment of choice.

Hemangioma. One of the most common benign growths found around the mouth or involving the buccal mucosa is hemangioma. This tumor is more frequently seen in small children than in adults and varies considerably in size. One of the most important considerations of this tumor is the recognition of its potential danger when found and particularly when a parent of the patient gives a positive history that it is increasing in size. They can grow amazingly fast and to alarming sizes within a relatively short time. The two best methods of treating them are: injections of a scleroding substance as sodium morrhuate, or surgical excision. Treatment by radiation or implants of radon seed is frequently mentioned as an acceptable method of treatment, but many cases so treated fail to show a complete destruction of the tumor and later report for treatment of a tumor which continues to grow and which is associated with a mass of scar and altered tissue, as a result. A large percentage of these cases can be satisfactorily treated and the tumor completely sclerosed by injections of sodium morrhuate, and where this can be done it is probably the method of choice. In instances of large, bulky tumors which do not respond to injections of sodium morrhuate, surgical excision is sometimes necessary. We feel, however, that injections of sodium morrhuate should be first attempted in practically all of these cases and only given up when ample evidence is presented that growth of the tumor is not held in regression by injections.

Cancer of the mouth. The tissues of the lips, the mucosa lining the buccal cavity and covering the alveolar ridges, as well as the tongue, are sites for the development of cancer in a high percentage of cases. Chronic irritation is unquestionably a common factor in the production of these malignancies of the mouth. Cancers of the lip are commonly treated by applications of radiation and with apparent good results. Occasional cases, however, are seen subsequent to a presumed cure, with evidence of residual disease which has become widespread. Due to the tendency of squamous cell lesions of the lip to metastasize rather early, it is felt that less chance is taken if such lesions are surgically excised. Cancer involving the buccal mucosa or the alveolar margins or even the tongue requires the same consideration in treatment as one would apply elsewhere on the surface. If one can presume to offer this end result with certainty by the application of radiation to these growths, this may be a satisfactory method of treatment. Here again one must bear in mind the possibility of subsequent growth arising from tissues so radiated even though the initial growth seems to have been cured. Personally, I feel that lesions of the mouth can be removed with a

greater certainty through surgical excision than by radiation. The argument is proffered that this may be true but the defect is more extensive, and, therefore, should influence the decision for radiation. Even though this be true we still see many patients who have had presumptive cures by radiation who seek treatment of residual growths that have not been cured by this radiation and which show much more extensive invasion than would have been dealt with had they been treated surgically when first seen. Many of these extensive lesions are presumed to be incurable or inoperable because of the apparent defect which might result. Here again we must realize that extensive surgical excision, even to the point of taking out the greater part of one side of the face, may be necessary, but can be done and a fairly satisfactory repair effected by advancement of the necessary tissues into the defect. Satisfactory repair of massive defects of the face may be accomplished by means of compound pedicle of skin, fat and muscles which are lined with a skin graft. Subsequent to advancing the soft parts tissue into the defect, bone grafting may be done to replace the loss of a mandible, or a portion of the maxillae. Other less involved defects lend themselves to be corrected by means of sliding or rotating flaps or even skin grafting. With more refined methods at hand for the repair of massive defects, the patient now has much less concern over massive extirpation of tissues than was seen a few years ago.

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DOCTORS MAKING SPEECHES*

In "As You Like It" Shakespeare has one of his lesser characters say that "words do well when he that speaks them pleases those that hear." Speech should not only please but should be expressed in a manner that will deliver the thoughts of the speaker without distraction. Too often mannerisms used by speakers turn the thoughts of the audience from the subject. Mannerisms may be an unconscious habit in those with great ability, who have given little or no thought to public speaking. And mannerisms are very often the result of not being sure of oneself, or they may be used as a cloak to cover the nakedness of unpreparedness, timidity, or ignorance.

All mannerisms of public speakers are artificial and tend to dominate the thoughts of the listeners. A speech is bad when the audience is more conscious of the speaker than the speech. In science we speak to teach, and, if one's subject is not clearly and interestingly presented, it loses its teaching value. To indulge in any type of mannerism which is expressed in bodily motion must result in some

*Presidential Address presented at the Second Annual Meeting of the Southwestern Surgical Congress, Sept. 25, 1950, Denver, Colorado.

degree of dispersion of thought impulses. If a thought impulse trickles to any part of the body during the making of a speech, it must slice off bits of thought material that should be directed to the speech center. To speak effectively requires the undivided attention of the speaker.

There is a vast difference between mannerisms and gestures. Well selected words, the tone of the voice, and suitable gestures make a speech impressive. But gestures are bad if they are poorly timed or inappropriate, and attract more attention than the words of the speaker. Manner of speaking and mannerisms are also different. Our personalities all differ and so must our manners of expression.

The gift of the orator is not necessary or desirable in the presentation of scientific subjects. Oratory has been defined by someone as "the ability to make deep noises from the chest seem like important messages from the brain." Such an estimate of some of our political spellbinders should not be difficult for a scientific mind to appreciate.

It is not in any spirit of ridicule that I discuss "Doctors Making Speeches," but rather to point out some of the unconscious foibles which are not uncommon among speakers of our profession. And it would be little less than heresy not to acknowledge the fact at this time that there are many men in the medical profession who are unsurpassed by anyone as public speakers. All of you have heard them and have been thrilled by their superlative diction and delivery.

Through the years I have been privileged to listen to many young men in our profession who were beginning their careers as public speakers on medical subjects, and have been much interested in the various mannerisms used by some of them, which detracted from the messages they tried to convey. These and other observations have stimulated me to discuss a few of the mannerisms of the physician as a speaker, and to comment upon some of the impressions they have made upon me as a listener.

One of the most distracting types of speakers is the one who walks up and down, and back and forth as he talks. We might call him a peripatetic perambulator, or, in more modern parlance, a "walkie-talkie." To sit on a front seat and watch such a restless spirit can only detract from anything he is saying, and forces one to wonder when he will trip over his own feet. Then there is the back and fill type, who walks toward you a few paces and then retraces his steps as if he were trying to gain new strength by backing up and going forward again. Constant pnudeflection is an exercise occasionally indulged in which gives one the impression that the speaker is trying to boost his thoughts by pumping them from below. The swinger

and swayer must entertain himself because he does not impress his audience. Such an eccentricity may be proper in a pianist but not in a scientist.

Other types of confusing speakers are the leg-crosser, the leg-shifter, the table-sitter who swings his legs, the table-rubber, the fingernail tapper, the foot-shuffler, and the eyeglass or watch-charm twirler. All these are examples of speakers who need their hands or feet tied.

The tired-looking, expressionless, or listless speaker, before he is well started, forces you to wonder how soon he will finish. His voice is a humdrum of monotony. You do not listen to what he is saying, but spend your time waiting for the end. The longer you wait, the less you think of his words, and when he has finished you know naught of what he has said. As he sits down a feeling of sorrow pervades your being, because you have developed the conviction that he has overtaxed his strength. If one has no enthusiasm for a subject he should refrain from speaking. A dead sparkplug makes the engine misfire. In the same class with the tired, expressionless speaker is the mumblor. If he reads his speech, he reads and reads, and never looks up. He mumbles to himself, directs his voice toward his shirt front, and toils to the end of his discourse with no one the wiser for his remarks. The mumblor creates the impression that he is discontented or doubts the advisability of facing his audience. The "uh-ah" speaker belongs in this tiresome group. To precede every sentence with a hesitant "uh-ah" destroys the force of any address. It shows that no thought has been given to public speaking, or that the speaker cares little for the impression he makes.

The teeterer on heel and toe is a disconcerting speaker. It must require some thought to keep balance. What his thoughts gain by the continuous teeter-totter is difficult to imagine. There must be some type of stimulus to his vanity that makes him think that his delivery is enhanced by his antics. A little pomposity usually is apparent in such a speaker. His exercise should be good for the prevention of varicose veins.

Then there is the timid soul, who really may have something to say, but is so doubtful of himself that he frequently smiles and smirks as if he were apologizing for his remarks. The making of grimaces when talking hardly impresses an intelligent audience. Grimaces should be reserved for the entertainment of children.

The man who talks to himself is exasperating. He is the colorless speaker. His voice is often so low and monotonous that only a fleeting grasp of his meaning is audible. The opposite of this type

is the ranter. His ranting far outstrips the importance of his message, and often he speaks so rapidly that his spoken words meet his thoughts on the rebound. In other words, he speaks faster than he thinks. The rambler flits from one thought to another and often does not complete his sentences. He does not have himself or his subject systematized. When he has completed his remarks it is difficult to draw any conclusions from what he has said.

To speak with hands in pockets is not a grievous fault providing the hands are kept in pockets and further providing that they do not jangle keys and coins noisily, or surreptitiously scratch parts of the anatomy which may be evident to the audience.

To try constantly to be funny is an abomination in scientific discussions. A ready wit, when applicable, helps to hold the interest of an audience, but forced efforts to amuse result only in the antics of buffoonery, or the gurgles of inanity.

The strutter fills you with disgust. His mannerism is much more profound than his thought. He swells when he talks and often opens his mouth as if something important were coming out, but it stays in. He does not please; he does not instruct, and he does not entertain.

The long-winded speaker may not be accused of mannerisms but he is certainly oblivious to the effect his speech is having on the audience. To speak too long is to tire hearers and show lack of consideration for the speaker who follows. Several long-winded speakers can ruin any meeting.

Teachers in medical schools are often guilty of imposing upon medical students by indulging in dull talks that cannot possibly interest anybody, much less medical students, who are often very tired listeners. Students must tolerate tiresome speakers because they cannot help themselves by walking out. In this respect students are often more courteous than their teachers. To teach properly is no easy task and cannot be done by haphazard methods. In my own experience as a medical student I recall that we had a very brilliant medical scholar as a teacher who could not make his talks interesting. His ward rounds were called by facetious students "shifting dullness."

Teachers occasionally take advantage of medical students by smoking while they are trying to teach. One wonders how a smoke screen can help a teacher. There must be some comfort in puffing while he prates. Josh Lee, in his book, "How to Hold an Audience Without a Rope," calls this "leaning on a cigarette for poise." If one is speaking interestingly, he has no time to smoke.

SUMMARY

The requirements of a good scientific talk are few and simple. One should stand squarely on his feet and talk clearly, simply, and confidently. The microphone is one of the greatest assets to public speaking since the days when Demosthenes mouthed pebbles to improve his oratory. One must stand still when he speaks through a microphone.

Have something to say and do not have to say something. James Russell Lowell once said that, "blessed are they who have nothing to say, and who cannot be persuaded to say it."

If one has any intimation that he may be called upon to speak, he should be prepared. A good extemporaneous speech is almost invariably the result of much previous thought and study. If one is unexpectedly called upon to discuss a subject he knows little or nothing about, it is wiser to refuse than to confuse.

If any of my friends should feel compelled to comment about my lack of fitness for the above remarks, I defend myself with the words of Ralph Waldo Emerson (to which I do not fully subscribe) who said that "no sensible person ever made an apology."

THOMAS G. ORR, M.D.

Kansas City, Kansas.

THE AMERICAN SURGEON

Beginning with this issue of the journal, January, 1951, several changes have been made. First, the name has been changed to THE AMERICAN SURGEON. Second, the editorial staff has been reorganized. Several names will be dropped and new names added from time to time and for that reason the names of those comprising the editorial board will be omitted for the present. Later all names will be published.

Doctor Thomas G. Orr, Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas, was elected editor. Several changes in editorial policy were made.

BOOK REVIEWS

The Editors of THE SOUTHERN SURGEON will at all times welcome new books in the field of surgery and will acknowledge their receipt in these pages. The editors do not, however, agree to review all books that have been submitted without solicitation.

THE CLOSED TREATMENT OF COMMON FRACTURES. By JOHN CHARNLEY, B.Sc., M.B., F.R.C.S., Assistant Honorary Orthopedic Surgeon, Manchester Royal Infirmary; Visiting Orthopedic Surgeon, Park Hospital at Davyhulme; Lecturer in Orthopedics, Manchester University; Late Hunterian Professor, Royal College of Surgeons. Baltimore, Md.: The Williams and Wilkins Co., 1950. 190 pages. \$7.00.

The author states in his preface that the book is written primarily for the resident casualty surgeon. He has endeavored in this small volume to describe in detail what he considers the essential steps in the closed reduction of common fractures. He has emphasized the ease with which perfect reductions can be obtained by closed methods when the injury is fresh. The author recognizes that some individuals are more naturally equipped for acquiring manipulating skills than others, but it is unlikely that there is any special gift which cannot be conscientiously acquired by everyone. The biggest handicap in doing closed reductions is the surgeon's lack of having a clear mental picture of exactly what he is attempting to do. It is with this in mind that the author is trying to create pictures for the surgeon to visualize in his mind's eye. It should be the aim of a good manipulative surgeon to know that a fracture has been reduced by a sense of touch without depending on the x-ray. The fracture should, however, be checked roentgenographically. He attempts to re-emphasize the nonoperative methods and to show that far from being a crude and uncertain art, the manipulative treatment of fractures can be resolved into something of a science.

The first chapter deals with the mechanics of conservative treatment. Here there are figures illustrating the mechanics as well as x-rays of the breaks themselves, all of which are clearly explained in the written word. The second chapter deals with joint movement in conservative methods, while the third deals with the treatment of fractures without plaster of Paris, and the fourth deals with plaster technic. The remaining twelve chapters take up the specific types of fractures, dealing with them in an orderly manner, first with the anatomy, next with the mechanical analogy, then the technic as well as some words of caution concerning complications.

This volume seems to fulfill adequately the author's aim in being a text for the resident casualty surgeon. It, however, goes further than that, in that it is a good text for those who are involved in general practice or general surgery and who do an occasional fracture. It is probably too elementary for the master orthopedic surgeon.

A. H. LETTON, M.D.

SURGERY OF THE EYE: INJURIES. By ALSTON CALLAHAN, M.D. 240 pages and 367 illustrations (20 in full color). Springfield, Ill.: Charles C Thomas, Publisher, 1950. \$11.50.

This book is the outgrowth of the author's extensive experience with the subject which began in an army ophthalmic center during World War II. The book deals not only with the surgical management of injuries to the

globe such as burns, traumatic cataract, detachment of the retina, intra-ocular foreign bodies, etc., but also more extensively with the plastic and reconstructive surgery of the lids and orbit. The surgical procedures advocated in the book are those which the author has found, after experience with various methods, to give the best results in his hands. Many of the procedures and technics are original with the author. The book is beautifully printed and the excellent reproduction of drawings and photographs simplifies interpretation of the text. Although the book limits itself to the surgical repair of injuries to the eye and adnexa, such considerations extend into all fields of ophthalmic surgery. For this reason, the book is a highly recommended up-to-date guide for all general ophthalmic surgeons. Unique in such books is a chapter devoted to "ophthalmopedics," or mechanical appliances which aid in reconstructive surgery.

F. PHINIZY CALHOUN, JR., M.D.

ABSTRACTS FROM CURRENT LITERATURE

CONSERVATIVE SURGERY IN GYNECOLOGY. Robert James Crossen. *Texas State Journal of Medicine* 46:746-750 (Oct.) 1950.

In reemphasizing the importance of conservatism in the surgical treatment of pelvic diseases in women during the childbearing age, Crossen hopes to inspire a more judicious use of the scalpel.

Though myomectomy for the treatment of myoma of the uterus had until recent years become an almost forgotten procedure, in some centers the swing has been to a more conservative attitude. This has resulted partly from the excellent monograph by Bonney entitled "Extended Myomectomy and Ovarian Cystectomy." In 1923 Bonney made a most important contribution in the introduction of the Bonney clamp which, when properly applied, controls temporarily the blood supply to the uterus so that multiple myomectomy can be accomplished with a minimal blood loss. In recent years, mortality rates in large series of less than 2 per cent have been reported. Myomectomy has enabled some women who have had repeated miscarriages to have living children. Crossen considers high hysterectomy with preservation of menstrual function to be preferred to myomectomy in multiparous patients in their middle or late thirties.

The hazard of inadvertent kinking of the tube or blockage of the fimbriated end of the tube in covering an ovarian stump is brought to mind. In regard to plastic operations on the tubes following inflammatory disease, Crossen cites figures which reveal that this procedure is followed by conception and live birth only once in every 22.5 operations and states that the couple should be informed of the small chance of success before this procedure is undertaken.

Advocating meticulous dissection for removal of large ovarian cysts with preservation of the remaining functional cortex, the author points out that bilateral polycystic disease of the ovaries with only slight enlargement requires careful evaluation of the advantage to be gained from surgery. The sporadic reports of successful treatment of menstrual dysfunction and sterility by ovarian decortication revives interest in the procedure at intervals. The exact mechanism by which relief of symptoms is obtained is not exactly clear. Careful selection of cases for decortication is essential and the operation should be resorted to only after more conservative methods have failed.

Though the treatment of endometriosis at or near the end of the childbearing period is radical, ovarian function should be preserved when possible in women under 35. In the great majority of the cases preservation of one or more ovaries is followed by a period of at least five years in which the patient will require no further surgery. In about one-fourth of the cases in which conception is possible, pregnancy will result. The hormonal treatment of endometriosis will require further study but shows some promise in the conservative treatment of this disease and though it is not a panacea, it should be tried before resorting to surgery or radiation.

Reports of two cases in which conservative radiation was employed in the treatment of endometriosis are included, one with small dosage of x-ray and the other with radon seed implantation at the time of surgery. These were followed by symptom free periods with normal menses of 10 and seven years respectively.

R. H. S.

TREATMENT OF PAPILLARY CARCINOMA OF THE THYROID WITH LATERAL CERVICAL METASTASES George Crile, Jr. *American Journal of Surgery* 80:419-427 (Oct.) 1950.

Though papillary carcinomas of the thyroid commonly metastasize to the lateral cervical lymph nodes, metastasis does not imply poor prognosis. In Crile's experience, those patients whose leading symptom has been lateral cervical metastasis have a better prognosis than those whose leading symptom is tumor of the thyroid gland. His statement of the peculiarities of this tumor is quoted:

"1. Papillary tumors of the thyroid usually grow slowly and are of the lowest degree of malignancy. We have followed one patient's progress for over 27 years during which time no treatment has been given. Yet the metastatic nodules, proved by biopsy have not enlarged significantly.

"2. Even when the lateral cervical metastases enlarge steadily, they rarely become invasive or involve either the great vessels or the sternocleidomastoid muscle. The nodules, therefore, can be removed easily, either individually or in groups.

"3. The metastatic nodules are true tumor emboli lodging in lymph nodes. Prolonged observation of a large group of patients after removal of individual nodes or groups of nodes has failed to reveal any tendency of the metastatic tumors to recur locally other than in lymph nodes outside the field of the original operation.

"4. Prolonged observation of a small group of patients whose metastatic nodules in lymph nodes were overlooked at the time of removal of the primary tumor indicates that these metastatic nodules remain localized and grow slowly over a period of 5 to 10 years. After the primary tumor is completely excised, no new metastatic nodules develop. Apparently the metastases do not tend to metastasize.

"5. The lateral cervical nodules usually can be removed as easily after many years of observation as when they are first recognized.

"6. Metastatic nodules in papillary carcinomas of the thyroid are not distributed through the usual channels followed by squamous cell carcinoma of the face or oral cavity, but through a system of deep lymphatics which bear metastases (1) to the deep nodes of the carotid sheath sometimes anterior to and usually behind the great vessels; (2) to the medline in the thyroglossal tract; (3) to the posterior triangles of the neck; (4) to the chain of lymph nodes behind the thyroid along the course of the recurrent laryngeal nerve; (5) below the thyroid, along the thyroidal vessels; (6) to the superior mediastinum and (7) to the axilla. Metastasis to the lungs is rare but may occur."

Crile believes that radical and mutilating block dissections with removal of the sternocleidomastoid muscle are neither necessary nor desirable and he states that papillary carcinoma of the thyroid can be treated as effectively with complete removal of the affected lobe or lobes and removal of the lateral cervical metastases individually or in groups as by block dissection. The material covered in this report consists of 18 conservative cases. Local removal of the various groups of involved lymph nodes has resulted in the complete control of the tumor in all cases. In about half the cases, where the nodules were confined to the lower neck, the entire procedure of excision of the lateral metastases and hemithyroidectomy was performed through the usual thy-

roidectomy incision. The strap muscles are divided for additional exposure. The metastatic nodules usually occur in groups and are surrounded with loose areolar tissue and fat which tend to bind them together facilitating the delivery of inaccessible nodes in the upper mediastinum. If the most accessible node is grasped and traction made upon it, other involved nodes in that group will usually be delivered. Similarly, axillary metastasis may be removed by dissecting the skin flap down over the clavicle, separating the fibers of the pectoral muscles, and pulling out axillary metastases in their fatty envelopes from the apex of the axilla.

Crile concludes that the most important aspect of treatment is the total removal of the primary tumor in the thyroid. Removal of the lateral cervical metastases individually or in groups through cosmetically placed incisions gives as good a chance of cure as more ambitious and radical operations. He feels that Roentgen therapy is rarely necessary and even more rarely effective.

The report of a case of papillary carcinoma with pulmonary metastasis which regressed after treatment with radioactive iodine is included.

R. H. S.

QUANTITATIVE STUDIES ON THE MECHANISM OF GASTRIC SECRETION IN HEALTH AND DISEASE. Lester R. Dragstedt, Edward R. Woodward, Edward H. Storer, Harry A. Oberhelman, Jr., and Curtis A. Smith. *Annals of Surgery* 132:626-640 (Oct.) 1950.

In a study to determine by quantitative methods the relative importance of the mechanism of stimulation of gastric secretion, Dragstedt and his co-workers have studied patients with various types of peptic ulcer as well as normal dogs with isolated gastric pouches. They have reported elsewhere the results of their investigations into the nervous phase of gastric secretion but in this report they include the results of a representative experiment. For the present study, 12 healthy dogs prepared with totally isolated gastric pouches of the type devised by Dragstedt and Ellis were used. The gastric secretions were studied both before and after thoracic vagotomy. The data obtained indicate that the nervous phases are more important than the intestinal phase in the ratio of at least four to one. The reduction in gastric secretion following vagotomy seems to persist in the dog for at least two years which is in line with the previous observations in the persistence of the effects of vagotomy on the nocturnal secretions in ulcer patients.

In quantitative studies of various preparations, the investigators have been able to demonstrate that, though complete removal of the antrum of the stomach will produce a decrease of 86 per cent in the output of hydrochloric acid and that exteriorization of the antrum so that it does not come in contact with food produces a similar reduction, incomplete excision of the antrum has no effect on the secretion. Exclusion of the antrum after the manner of Finsterer produces no reduction in secretion in about 50 per cent of instances and moderate to marked decrease in the remainder. Though transplantation of a portion of the fundus of the stomach into the duodenum has no stimulating effect on gastric secretion, transplant of the antrum into the duodenum or into the colon as a diverticulum produces definite stimulation of secretion. These findings demonstrate that the antrum of the stomach when it comes into contact with food secretes a powerful gastric stimulant (the gastrin of Edkins) and is responsible for the gastric phase of secretion. They conclude that in normal dogs the nervous mechanism accounts for about

45 per cent of the total gastric secretion, the gastric phase another 45 per cent and the remaining 10 per cent is attributed to the intestinal phase.

After making volumetric and chemical studies of the gastric secretions in 81 normal surgical patients, 135 patients with duodenal ulcer, 70 patients who had had vagotomy for peptic ulcer, 14 patients with gastric ulcer and 10 patients who had had vagotomy for gastric ulcer, the authors have arrived at the following conclusions: The fasting nocturnal secretion in duodenal ulcer patients is three or four times greater than normal and they secrete about twice as much acid in response to insulin or histamine. Following complete vagotomy, the response to insulin is abolished, the response to histamine decreased by 60 to 80 per cent and the fasting secretion reduced to about one-fifth of the former level. On duodenal ulcer patients, the nervous phase of secretion probably accounts for 80 per cent of the gastric juice secreted.

R. H. S.

THE EFFECT OF DEFINITIVE SURGERY ON DUODENAL ULCER DISEASE. A Comparative Study of Surgical and Nonsurgical Management in 997 Cases. Francis D. Moore, William P. J. Peete, John E. Richardson, John M. Erskine, John R. Brooks, and Horatio Rogers. *Annals of Surgery* 132: 652-680 (Oct.) 1950.

Moore and his co-workers in reviewing the records of 1,246 patients with duodenal ulcer managed with or without surgery at the Massachusetts General Hospital during the period from 1942 to 1946 were able to follow 997 patients through mid-1949 and collect enough data on them to make a valid determination of the success of the regimens. They have realized the difficulty in evaluating results in a nonmalignant condition and after establishing a very logical classification of the pattern of results have attempted to evaluate the results by the same criteria whether the technics and skills of medicine or surgery formed the predominant feature in the management of the individual patient. They deplore the term "intractable ulcer" and propose the concept of "progressive" or "virulent" duodenal ulcer disease to express the nature of the condition in that fraction of the ulcer population who do poorly without definitive surgery. The formulation of criteria for the determination of this status is quoted:

"I. On the basis of these data it is possible to advance a set of primary and secondary criteria for the diagnosis of progressive or virulent ulcer disease:

"A—Primary criteria

1. One perforation in the past, with present ulcer symptoms.
2. One acute hemorrhage requiring blood transfusion.
3. Progressive pain over a two-year period under a physician's care and advice in the patient's normal living environment, at work.

"B—Secondary criteria

1. A male with duodenal ulcer symptoms under a physician's care.
2. A male with onset of symptoms prior to the age of 20 or subsequent to the age of 65.

"II. If two of these criteria, at least one of which must be primary, are present, the diagnosis of progressive virulent ulcer disease may be considered established.

"III. Once established, the outlook for a satisfactory result on nonsurgical management is poor and the intrinsic mortality elevated.

"IV. If surgical skill and facilities are available for accomplishing subtotal gastrectomy with a low mortality, the patient should be offered this procedure.

"V. If three criteria are present, such surgery should be urged. Symptomatic alleviation under hospital condition does not alter the importance of these criteria. Obstruction is an end-stage in the natural history of ulcer, and in itself requires operation for relief; it therefore does not appear amongst these diagnostic criteria.

"VI. If subtotal gastrectomy cannot be safely accomplished under the conditions available, we have no irrefutable evidence that other operations can replace it."

The exhaustive analysis of this large group of cases would indicate that the mortality from hemorrhage, perforation and late obstruction in non-operated patients appears to balance the intrinsic hospital mortality of definitive surgery. Following definitive surgery only about half as many patients have an unsatisfactory result in symptomatic or economic terms as do those managed without surgery.

The authors conclude that the diagnosis of duodenal ulcer is not enough and that the doctor must proceed to a consideration of a more important diagnosis, "progressive virulent ulcer disease," and that if this diagnosis be established subtotal gastrectomy should be undertaken. "Such a conclusion can be acted upon conscientiously only when the surgical skill and facilities are available to permit performance of subtotal gastrectomy with an acceptable mortality. A policy for each hospital can only be made after critical study of its own cases."

R. H. S.

HISTOPLASMOSIS. A Common Cause of Appendicitis and Mesenteric Adenitis.
Alan Raferty, Peter C. Trafas, and Roy D. McClure. *Annals of Surgery* 132:720-728 (Oct.) 1950.

Since Darling first described histoplasmosis in 1906, attention has been focused largely on the fatal form of the disease. Recent investigations have revealed the benign form of the disease to be very common and of wide geographic distribution. Emmons has recently demonstrated a large animal reservoir in rodents of Virginia and Georgia. Raferty has established gastrointestinal histoplasmosis as a common childhood disease with demonstration of the organism *Histoplasma capsulatum* in diseased tissue of the gastrointestinal tract. During the study of the disease in children, it became apparent that this cause of lymphatic hyperplasia was of importance in the production of abdominal symptoms in all age groups and that the organism could be demonstrated in a significant number of specimens.

The material studied in preparation of this report consisted of surgical specimens from cases of appendicitis and mesenteric lymphadenitis in the Henry Ford Hospital during a ten year period and similar current specimens. A total of 2,135 cases of appendicitis and 30 cases clinically diagnosed as mesenteric lymphadenitis were encountered in the ten year period. Twenty-one current cases of appendicitis and one case of mesenteric lymphadenitis were studied. In addition to pathological study of the specimens with special staining technics being carried out in all cases, cultures at body temperature and room temperature as well as the inoculation of mice and chick embryos with macerated tissue was carried out on the fresh specimens. In mouse autopsies,

the authors were impressed with the lymphoid hypertrophy of reactive pattern similar to that seen in human cases.

The typical pathological picture observed microscopically consisted of lymphoid hyperplasia with large phagocytic cells scattered throughout the lymphoid follicle giving it a "starry sky" appearance. On high power study, the *Histoplasma capsulatum* organisms are observed within the cytoplasm of these phagocytes.

In the cases studied, a 5 per cent incidence of histoplasmosis was noted in appendicitis and an incidence of 43 per cent in mesenteric lymphadenitis. Review of the clinical histories revealed affected cases to suffer from a low-grade chronic disease. Four illustrative case reports are presented and discussed.

R. H. S.

SECONDARY OPERATIONS FOR PEPTIC ULCER. Frank Glenn. *Annals of Surgery* 132:702-710 (Oct.) 1950.

Of those patients with peptic ulcer who require surgical therapy, about 80 to 85 per cent will be cured or improved by the first definitive surgical procedure employed. Reinhoff found that 11.1 per cent of 260 patients required secondary surgical treatment. Secondary surgery becomes necessary in instances following every type of surgical procedure employed in definitive treatment. The indications for further surgery commonly appear within five years but they may continue to arise for periods up to 25 years following primary operation.

Glenn has studied 113 patients who over a period of 17 years have had secondary definitive operations at the New York Hospital-Cornell Medical Center and this study is the basis for this report. About half of these patients had had their primary surgery done elsewhere. Seventy-seven per cent had had gastroenterostomy primarily, 15 per cent had had gastric resection, 2.6 per cent had had vagotomy, and the remainder had had miscellaneous other procedures.

The most common condition leading to secondary operation has been jejunal ulcer. In certain instances there was a persistence or recurrence of duodenal ulcer. Gastrojejunal colic fistula developed in 17 cases where the secondary operation had been delayed too long.

The time interval between primary and secondary definitive procedure ranged from 14 days to 36 years. A total of 149 operations were performed on the 113 patients over a period of 17 years. Twenty-eight patients required a third operation, four required a fourth and one patient required six. Procedures employed were as follows: Gastroenterostomy 18, Dismantling 12, Gastric resection 78, Vagotomy 20, Miscellaneous 21. Gastroenterostomy and dismantling operations are to be condemned and most of those in this series were done during the early years. Of the 113 patients, 66 are symptom free, 12 are improved, 5 have demonstrable marginal ulcer and 6 are lost to follow up. Three patients died ultimately of ulcer or its complications, 11 died postoperatively and 10 died of unrelated cause.

The postoperative mortality from secondary operation in this series is 9.7 per cent and added to those who ultimately died of ulcer, the rate of complete failure is 12.4 per cent. Less than 60 per cent are symptom free. These figures point up the gravity of the situation when patients are not relieved by the primary operative procedure.

Glenn concludes from his studies that an adequate gastric resection removing two-thirds to three-fourths of the stomach is the procedure of choice primarily as well as for secondary treatment of failures. Conviction on the part of the surgeon that this will improve his result should encourage him to exert the extra effort necessary to accomplish it.

"It is recommended, therefore, barring contraindication, that resection of three-fourths of the stomach be done for all peptic ulcers requiring surgical treatment. The probability of a marginal ulcer developing thereafter is slight, perhaps less than 5 per cent, but if it does occur, then vagotomy should be the next procedure. Should this fail as well, then a total or near total gastric resection should be considered. This is the gamut of our surgical armamentarium at the present time. It constitutes an effective policy that if followed should result in a very small number of failures compared to the total number of patients treated surgically. For these few we hope that drugs such as Banthine, now showing promise, will control these distressing clinical problems when they persist."

R. H. S.

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DR. D. L. GARRETT.....	701 Medical Arts Building, Tulsa
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DR. ENNIS M. GULLATT.....	The Sugg Clinic, Ada
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Applications now being received for July, 1951, residency in otolaryngology and bronchoscopy and postgraduate instruction in anatomy, oncology, radiology, pathology, and allergy. Approved by AMA and ACS—affiliated with Emory University School of Medicine. Cash allowance and full maintenance. Apply Superintendent, Grady Memorial Hospital, Atlanta, Georgia.

